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Never Good Enough: Health Care Workers and the False Promise of Job Training

Ariel Ducey

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For Ty

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Introduction

Health Care and Getting By in America

Hospitals are the economic and social centers of many urban neighborhoods in the United States, but in New York their number and size is unusual. The campuses of major academic medical centers occupy entire city blocks and their buildings loom over the apartment buildings, brownstones, tenements, and public housing projects that surround them. Seen from above, hospital campuses are as easy to pick out as famous city landmarks; approaching them on the street, they are like magnets, drawing in thousands of workers and patients each day.

Inside these metropolises, medical students shuffle between lecture halls, the medical library, and patient units, and physicians conduct procedures, check patient charts, and write orders. Doctors, however, are only a minority of people working in such hospitals. Many spend only a few hours of the day there before returning by car service to their private offices in more serene settings. They are even less numerous in the smaller community hospitals that dot the city. Nurses and nursing assistants, overwhelmingly women, make up the bulk of the hospital workforce, and they arrive to

work by subway and bus in their scrubs and thick-soled shoes, an ID card hanging around their necks—many on a colored cord that identifies their union. There are other workers too, overwhelmingly people of color and immigrants: maintenance workers, food service workers, housekeepers, laundry workers, technicians of many types, social workers, paramedics, therapists, and therapy assistants—workers whose experiences claim less scholarly and journalistic attention, perhaps because their work seems less crucial to patient care. Patients and their loved ones are tourists in these places (though some unfortunately become like members of the community), who disrupt the movement of hospital staff when they stop short in busy corridors to look at the signs hanging from the ceilings or the colored lines on the floors intended to guide them through the labyrinth of buildings.

New Yorkers work hard in a variety of service industries, old and new: as retail salespeople, waitresses, cab drivers, street vendors, garment workers, teachers. But health care is unusual because it offers the possibility of economic security for entire communities. The proliferation of health care jobs available to women, immigrants, and people of color constitutes the possibility of reversing, or at least slowing, the growing inequality that characterizes contemporary America. Already, over one in ten employed Americans work in health care settings or occupations, while in New York City, where health care is the largest employer, that number is closer to one in eight.[1] At the peak of the dot-com bubble, in 2000, business services briefly surpassed health care as the city's number one private employer, but the bubble's collapse shortly thereafter returned health care to its traditional leading position.[2]

In hospitals and the neighborhoods they dominate you can still feel the buzz of working-class New York, the city that was for a long time defined as much by the tradespeople, craftsman, and semiskilled laborers in its sprawling and diverse manufacturing sector as it was by Wall Street traders and real estate brokers.[3] Health care has produced the working-class jobs that make up for the evisceration of the manufacturing sector in the traditional industrial strongholds of the northeast—at least partially. In New York City, health care added 21,400 jobs between 2000 and 2003, while manufacturing lost 50,000 jobs in approximately the same period.[4] The northeast corridor stretching from Baltimore to Boston, the "nation's health epicenter," added 50,000 jobs between 2000 and 2002 while all other

industries combined shed 220,0000.[5] Even in Manhattan, hub of the nation's financial and commercial networks, health care is the social and economic anchor.

Not only is health care today the largest employer in New York City, but it is of central importance for workers in the "sub-baccalaureate labor market," those who have at least a high school diploma but not a baccalaureate degree, who may or may not have some college education.[6] Despite the hype about the "knowledge economy" and postindustrial, flexible, creative workplaces of advanced capitalist nations, three-quarters of workers in the United States do not have a baccalaureate degree.[7] Most of these workers are employed in the growing service sector, and the rate of growth of health care jobs nationally has even surpassed job growth in the service sector as a whole in all but a few years.[8] In 2004, six of the ten occupations projected to grow most quickly between 2002 and 2012 were in health care: medical assistants, physician assistants, home health aides, medical records and health information technicians, physical therapist aides, and physical therapy assistants.[9] Only one of those occupations, physician assistant (PA), typically requires a credential beyond the associate's degree. In New York City, estimates are that over one-third of the 375,000 jobs in health care are open to people with an associate's degree or less.[10]

There is no satisfactory term to denote this segment of the health care workforce, but I generally refer to those in it as "allied" health care workers.[11] Some of the health care workers included in my research started working in health care before they had a high school diploma, others have gone on to achieve credentials higher than an associate's degree; but they hold the kind of jobs that are the core of the sub-baccalaureate labor market. Sometimes I refer to them as "frontline" health care workers, which captures the fact that they are responsible for the day-to-day tasks that keep hospitals and health facilities running, from mopping the floors to bathing patients. Much of the social science literature on health care still gives the impression that physicians and registered nurses are the only care providers at the bedside, but the workers I profile in this book make fundamental contributions to patient care, sometimes at the bedside but also when they are not directly interacting with patients.

The quality of frontline health care jobs—their working conditions, status, wages—not only affects patient care, but determines the well-being of a growing number of Americans and their families. The quality of life

among those who do health care jobs in the sub-baccalaureate labor market is a litmus test of the U.S. economy and whether the recent transition from an economy based on manufacturing to one based on services warrants the optimistic outlook that corporate leaders and managerial theorists urge us to adopt. Health care work is a life-support system for the contemporary working class, and health care workers' experiences tell us just how much of the American dream can still be realized.

Labor unions' struggles are the reason the health care sector in New York City offers some of the most stable and secure work possible in the sub-baccalaureate labor market. In particular, New York City–based Local 1199—the union examined mostly closely in this book—has become one of the most influential labor organizations in the country. Merged with the Service Employees International Union (SEIU) in 1998 and known officially as "1199SEIU United Healthcare Workers East," its membership throughout the northeast totals nearly 300,000. In New York City, where its core membership remains allied health care workers in private hospitals, 1199's contracts and wages establish the standard to which all other city health care workers aspire, including more than 10,000 health care workers in the public hospital system, the Health and Hospitals Corporation (HHC), represented by District Council 37—an affiliate of the American Federation of State, County and Municipal Employees (AFSCME). Many smaller unions representing workers in nursing homes and home care agencies have merged with 1199 in recent years, and while DC37 was unable to prevent the gutting of the public hospital system in the 1990s, 1199 managed to protect most of its jobs.

1199's strategies toward the health care sector and how health care is financed and delivered, particularly under past president Dennis Rivera, have also become a template for other health care unions nationally. Indeed Rivera, who lead the union from 1989 to 2007, resigned only to head a new one million–member health care workers division within SEIU—called SEIU Health Care. That "union within a union" will unite 1199 with nearly forty other SEIU branches, representing hospital and nursing home workers around the country, and try to unionize more of America's nine million unorganized health care workers.

In the 1990s, resurgent neoliberal pundits and politicians in New York initiated a number of policy reforms intended to increase the role of markets and competition in the health care sector. As a result, consultants,

policy specialists, and regulators encouraged hospitals to undergo the same sort of "restructuring" and "reengineering" by then ubiquitous in the corporate sector. Unsurprisingly, this was really an attempt to cut costs and shift more work onto the least-paid health care workers. Hospital leaders also used this political context to argue that layoffs were inevitable and substantial wage increases inconceivable. In the face of this hostile environment, 1199's key strategy was to form a common cause with hospital leaders to lobby against pro-market reforms and shore up state funding for the hospital sector. 1199's pivotal 1992 contracts with New York City hospitals formalized a labor–management partnership and "endorsed the notion of labor and management working together to confront the challenges facing the healthcare industry."[12] Foremost among the support the union leveraged from the state beginning in the mid-1990s was hundreds of millions of dollars for training and education programs directed at frontline workers, reaching $1.3 billion by 2005[13] and creating a veritable health care workforce training industry. The union's decision to embrace job training programs as the solution to hospitals' threats of layoffs, as well as workers' demands for higher pay, better working conditions, and more meaningful employment, has since become pivotal to 1199's identity. The health care workforce training industry in New York City is the subject of this book, an assessment of who gains—and who does not—from it. Remarkably, the union emerged from the tumultuous 1990s as one of the most powerful labor unions in the country. Its expanding influence, however, was not accompanied by improvements in the working conditions faced by its members or the organization of the city's health care services.

These elements of the 1199 model under Rivera—forming partnerships with employers, lobbying for greater health care financing, and offering prospective management partners the opportunity for their employees to participate in training programs, many of them publicly funded—now form the strategic basis for SEIU's projected expansion around the country. Job training and upgrading is not only a signature piece of the negotiated benefit package advertised to prospective members, it is one of the major ways the union tries to demonstrate that it can "add value" to the health care industry and convince the latter to drop its opposition to organizing efforts. As Rivera explained to the *Boston Globe* in 2005, when the union was wooing top executives of Boston's major teaching hospitals, SEIU's pitch to nonunion managers is: "We've got to get to know each other. We want to

convince you that we are the best thing that could ever happen to you and your institution."[14] Boston Mayor Thomas Menino indicated he supported the union's organizing efforts, surely because the union endorsed his 2004 reelection campaign, but also because 1199 promised to provide workers with valuable training. "It's about workers' rights and workers' ability to move up in the economy," he said.[15]

1199's efforts to develop programs to train and retrain its members are, in some respects, confirmation of the union's foresight and concern for the rank and file. Nonetheless, the elaborate and extensive training and education system established for health care workers in New York in the 1990s, and the envy of labor unions around the country, largely failed to address, and in some instances reinforced, key problems in health care work and the health care system more broadly. The most heavily funded training programs could not fulfill their promise to provide more meaningful and better-paid work, better-skilled workers, and better jobs, especially since meeting these goals became the responsibility of training alone—training directed almost exclusively at frontline health care workers. Indeed these programs seemed to substitute for efforts to address other aspects of health care that required change, and upon which the working conditions and quality of life of 1199ers hinged: a fractured system of delivering patient care; organizational dysfunction; the disproportional and, from the perspective of medical needs, irrational emphasis on acute care rather than community-based services. Training programs deflected attention from these systemic problems and instead blamed them on the skills and attitudes of allied health care workers. Some training programs even cajoled workers to accommodate the market-driven health care reforms that had produced and aggravated the aspects of their working conditions they found most frustrating.

Frontline health care workers are always most vulnerable to the perpetual tides of health care "reform," but the particular conjuncture of policy and politics in mid-1990s New York meant that they bore the brunt of change in a new way. They were obliged to tweak their skills by "multiskilling," to recalibrate their attitudes through "soft skills" training, and, if those failed to fix the problems with their work, to take advantage of training and upgrading programs for an ostensibly better job. Through training and education, allied health care workers became not only targets of pro-market policy and restructuring mantras, but were blamed for

many of the problems in health care, from the organization of work and patient care to the financial viability of entire institutions. Both the content of many training and education programs and the sheer commitment of time they require reveal how individual health care workers are pressured to compensate for the irrationalities of America's health care "system," for the fact that their work is devalued, and for the inequities of an economy driven by the relentless creation of low-wage service jobs. For some individuals, the health care workforce training and education industry established in the 1990s created unprecedented opportunities for advancement. When viewed from the perspective of the consequences for health care workers as a whole, however, who in New York are also predominantly those who have been historically disadvantaged—workers of color, immigrants, women—the opportunities created by training and education also seem to be an unequal obligation to continually work more.

At the same time training programs expanded, workers' wages stagnated. Although the wages of 1199 members are better than those in many other service occupations and above the national average for health care workers, for most entry-level jobs they still hover near subsistence levels. Marie, an 1199 member and nursing assistant in a Bronx hospital, was making $14 an hour, or roughly $29,000 a year (before taxes) when we spoke in 2002—and wages in hospitals are significantly better than in home care or nursing homes. In the same year, the minimum hourly wage necessary for someone in Marie's position—a single adult with a school-age child living in the Bronx—to attain self-sufficiency was estimated at $14.44 an hour. Marie was in some ways better off than this measure suggests because she paid nothing for health care through 1199's benefit plan; she did not often have to pay for child care since her mother, who worked the night shift, cared for her eleven-year-old son after school; and her apartment was publicly subsidized (though her rent was about to be doubled). Her one-bedroom apartment was small, although she had made it comfortable. It was crammed with children's books and toys and the day I visited filled with the smell of baking banana bread. Nonetheless, Marie was able to get by in part because she lived in a cheap—and unsafe—neighborhood. She was afraid to let her son go outside alone. Marie was certainly not destitute, but she struggled to stay on top of her bills and earn enough to support her son's education. The self-sufficiency measure, while more realistic than other measures of wages and costs of living such as the federal

poverty level, assumes only minimum spending on the bare necessities each month—housing, child care, food, transportation to and from work (by bus or subway), health care, and taxes. For a family of Marie's size in the Bronx, the measure assumes they need to spend only $192 a month on everything else—the "miscellaneous" category. The measure makes no allowances for vacations, owning a car, any travel other than getting to and from work, entertainment, or even savings.[16]

Marie's experience exemplifies the insecurities of the sub-baccalaureate labor market, the pivotal role of health care jobs in that labor market, and the limitations of training and upgrading as an ostensible remedy to those insecurities. A thirty-year-old single mother born in Brooklyn (to parents from Puerto Rico), Marie had been laid off from the two jobs she obtained after dropping out of high school, first by a company where she performed clerical duties for over two years. The company reviewed hospital patient records for coding and billing accuracy but closed down after losing several major contracts. While working there from 1986 to 1988, Marie took home $365 in pay every two weeks. "I thought I was rich!" she laughed as she told me the story. In the meantime, she had obtained her general equivalency diploma (GED), so after being laid off she started college part-time while making due on her severance pay and eventually took another clerical job with a firm on Wall Street. When the firm learned she was pregnant, they "said that they couldn't keep on training me because I was due to give birth. They said that they needed somebody who was going to be in the position permanently... so they let me go." Marie said she became depressed, and after the birth of her son enrolled in public assistance, which she found to be a demeaning experience. She paid about $1,000 out of pocket for a certified nursing assistant (CNA) course in the early 1990s, but did not take the final exam because she was afraid she would not pass. A few years later, however, she completed and passed a different CNA training course, to which New York State sent her as part of its efforts to reduce its welfare rolls. She was then hired for her first nursing assistant job by a hospital just north of the city, in Westchester County, where her starting wage was $8.50 an hour.

For women like Marie, the stakes for success or failure in health care are high. Health care is one of the only avenues, perhaps the only one, for women in the sub-baccalaureate labor market to increase their earnings. According to an analysis of several surveys of income and educational

achievement, economic returns for most sub-baccalaureate certificates and associate degrees (wage gains above what workers would obtain with only a high school degree) vary widely, and "some kinds of postsecondary education provide no economic advantage at all." However, some health-related sub-baccalaureate credentials are consistent exceptions. Health-related occupations are the only field in which sub-baccalaureate certificates showed statistically significant positive economic returns for women over time; at the associate degree level, only health and business-related fields showed such returns for women.[17] Workers in health care who are able to advance beyond entry-level positions may achieve meaningful improvements in their quality of life. In 2001, the median hourly wage for a respiratory therapist in the New York City metropolitan area was $22.91 and for a registered nurse, $28.20,[18] and both occupations require only an associate's degree for employment. Health care occupations are furthermore one of the only exceptions to the finding that work involving caring labor is subject to a wage penalty of 5 to 6 percent for both men and women.[19] In sum, some jobs in health care are crucial sources of stable wages and benefits for women without a bachelor's degree. This is particularly true in wake of welfare reform, which placed strict limits on the number of years people can receive benefits and abruptly transferred many women into the ranks of the working poor. For many immigrant women, health care jobs are also by far the best alternative to domestic work.

Marie, not surprisingly, had regularly sought more education and training to improve the quality of her life, and she was aware of the union-driven opportunities seemingly sprouting up around her. In particular, all of the college and university officials I interviewed for this study had begun to offer contract courses for specific employers in the wake of federal and state support for the training of the health care workforce. (One study has found that over 90 percent of community colleges in the United States now offer contract training.[20]) Administrators and planners in postsecondary education in New York City now think strategically about the health care sector and its workforce as a stable source of students and revenue.

Most important is the City University of New York (CUNY), the largest urban institution of higher education in the country with seventeen undergraduate colleges and over 400,000 students. As the city's public institution of higher education, the extent of CUNY's involvement in the training industry has major implications for poor, minority, and working-class New

York City residents. In 1997, almost half of CUNY's first-time freshmen were foreign-born and over three-quarters were non-white, with blacks and Hispanics each approaching one-third of enrollment.[21] The doors that CUNY chooses to open and close to its students and the city's residents are therefore central in determining the quality of life for students who have been historically denied equal access to education and the labor market.[22] What does it mean, then, that by 2003, nearly half of CUNY's total enrollment, or 238,379 students, were in continuing education and workforce programs?[23]

Marie had enrolled at CUNY on a number of occasions, but faced some obstacles. Though she had passed several English and sociology classes at a four-year college, she could not continue toward a bachelor's degree without passing all sections of the CUNY entrance exam, a controversial admissions requirement implemented in 2000 for all four-year CUNY colleges. Largely because of a math phobia that had followed her since high school and seemed to get worse as years passed, she failed the math portion of the exam. When we spoke, Marie had quit college in frustration and was hoping to qualify for a nine-month, noncredit, licensed practical nurse (LPN) program offered at 1199 and CUNY's new training facility in the Bronx.

Plans for the new training facility were announced early in 2002 when, shortly before Dennis Rivera rewarded the Republican Governor George Pataki for his largesse toward the health care system by endorsing his bid for a third term in office, Pataki provided a $3 million grant to 1199 and CUNY to turn an abandoned department store on the once-illustrious Grand Concourse in the Bronx into a health care workforce training center. Financially, $3 million was a drop in the bucket, but symbolically, the training center was a means for these political actors to demonstrate their commitment to the well-being of health care providers, who in effect stood for hard-working New Yorkers as a whole.

Yet Marie's situation, and what she needs and desires, cannot be solved through more training and education alone. Looking at her credentials, Marie might seem to lack skills, yet in important ways her talents and abilities had never been adequately used. Marie, whom I observed several times at work, is a highly competent caregiver. She took great satisfaction in caring for people and wanted to become a nurse, both for the higher wages and to be a better role model for her son, to whom she was devoted.

She was capable of completing college-level academic work, but her fear of math exams would make it difficult to pass even the entrance test for LPN programs used in New York, widely judged to be more difficult than the standard entrance exam for more advanced RN programs. Marie's ability was not the problem. In junior high she had been accepted to one of the city's elite public high schools, which admit students on the basis of a competitive, citywide exam, but she did not recognize the import of that opportunity, nor apparently did those around her. She chose instead to attend another high school with a cousin, where she was bullied and eventually dropped out.

Even if Marie became an LPN, her daily responsibilities would be similar to those of an RN but her wages closer to those of a nursing assistant. In 2001, the median hourly wage for an LPN in the New York City metropolitan area was $16.69.[24] Moreover, LPN programs do not provide college credits toward a degree or advanced standing for the next step in a health care career. She was not even sure that becoming a nurse, of any kind, would alleviate one of her major sources of frustration—the feeling of being undervalued. She felt this way even though she had been recently "multiskilled." One of the major outcomes of the hospital-union partnership and the new emphasis on training and education, examined in chapter 4, was the transformation of hospital nursing assistants like Marie into patient care technicians (PCTs). PCTs were trained to perform (but not interpret) a number of procedures in addition to their previous duties, primarily electrocardiograms (EKGs) and drawing blood (phlebotomy). Marie's PCT credential, however, did not fix the devaluation of the caring labor she enjoyed providing nor was it a step toward a better job. It expanded her workload while adding "technical" tasks she said were boring and repetitive.

As we will see, 1199 has addressed the working conditions and division of labor in hospitals only within the bounds allowed by partnership with management, an arena in which training is readily embraced as the remedy to a variety of workplace ills. On the other hand, the union has been confrontational and exceptionally successful when it comes to organizing. Originally a small local of mostly Jewish pharmacists and drugstore clerks, in the 1930s 1199 and its communist leaders emulated their labor counterparts in the radical Congress of Industrial Organizations (CIO) and committed to organizing the unorganized.[25] They started with

those nearby—the drugstores' predominantly black porters and stockmen. As Leon Fink and Brian Greenberg explain in their meticulous history of Local 1199, the union had, by the mid-1950s, "all but exhausted its organizational potential in New York City drugstores," so leaders turned their attention to the underclass of workers in the city's private, nonprofit hospitals (known as "voluntary" hospitals), winning their first contract in 1958 at Montefiore Hospital in the Bronx. Prior to 1199's organizing and collective bargaining achievements, these workers—most of whom were black or Puerto Rican—had been essentially excluded from the postwar economic boom, their work regarded as a kind of philanthropy.

In the process, 1199 was able to surmount a feature of the 1947 Taft-Hartley Act, attached as an amendment by Congress under intensive lobbying by the American Hospital Association, which exempted nonprofit hospitals from provisions requiring employers to hold elections to determine whether workers wished to be represented by a union. Nonprofit hospitals argued that because they were charitable organizations, union demands for wage increases would undermine their ability to treat those who could not pay for hospital services. It was an irrational logic, one that pitted health care workers against a group of which they were a part, since they too lacked health insurance. In 1962, an 1199 strike forced then Governor Nelson Rockefeller to pass legislation that would include nonprofit hospitals under the State Labor Relations Act.

Within two decades, Local 1199 raised the living standards of largely immigrant and minority housekeepers, laundry workers, food service workers, and nurse's aides from abject poverty to something approaching the working class. Between 1958 and 1983 starting wages at the city's voluntary hospitals increased by 140 percent—adjusted for inflation—while the union also made gains in health and other benefits. Not all of these staggering wage increases can be credited to the union; some of it was made possible by increased government payments to hospitals and a rising minimum wage, but the extent of the increases would have been impossible without union pressure. Fink and Greenberg describe the "sense of release from the subsistence-oriented life-style of pre-union days" when a nurse's aide in 1977 said of her wages, simply, "now I'm able to go places."[26]

During the same period, 1199 consistently took progressive positions on larger social and political issues, associating with causes like world peace and civil rights—Dr. Martin Luther King praised it as his favorite union—a

tradition Dennis Rivera continued. Yet Fink and Greenberg also note that a condition of the union's organizing success in New York City was its promise not to intervene in the affairs of hospitals. They depict the political path of 1199's first generation of leaders (who ruled the union well into the 1980s), noting in particular the eventual separation between their formative political ideals—radicalism rooted in communism and the original CIO—and their practical approach to day-to-day union affairs and strategy. So today too, when it comes to health care—at the level of policy, the decisions of hospital administrators, and the working conditions of its members—the union has been far less progressive and aggressive.

In its recent organizing efforts in Boston, when the union's overtures to nonunion institutions are rebuffed, the union will—as part of pressure campaigns—obtain and publicize "information about publicly funded grants and bond debt as a way of monitoring how a hospital spends money." In those circumstances, "advocating for quality care is about more than just improving health care jobs," explains 1199, "it also means workers are proactively ensuring that public dollars are being used in the best way possible to improve the health care system."[27] Yet its history in New York suggests 1199's role as a self-appointed fiscal watchdog and defender of quality care is an ad hoc organizing tactic, not a mission that affects its relationships with employers once organizing is achieved.

1199 has, of course, justifiably criticized the commonly espoused view that workers' wages are a major cause of rising health care costs, which has dominated health care policy debates in the United States for decades. While the costs of health care are to an extent a legitimate concern, U.S. health care is singularly expensive because it is an employment-based, largely privately financed health care system, in which there are layers upon layers of excessive administrative costs, untold regulatory costs and subsidies for controlling the inequities produced by "markets," cadres of managers and consultants charging by the hour to respond to the perpetual irrationalities on which their very existence depends, the highest pharmaceutical prices in the industrialized world, and few controls on whether clinical innovations respond to the health needs of Americans. These cost escalators have little to do with the wages of frontline health care workers, as 1199 recognizes. Nonetheless, the so-called pragmatic way in which 1199 uses its now considerable political might in the arena of health care policy has reinforced precisely those aspects of the U.S. health care system that siphon

off resources and revenue that might otherwise go to workers' wages and patient care. Its strategies have even managed to reinforce, in the minds of many New Yorkers, the connection between its members' wages and skyrocketing costs, waste, and inefficiencies.

Unsurprisingly, frontline health care workers like Marie are the most insightful critics of what is wrong with how health care work is organized and care delivered, so before describing the training industry, the central topic of this book, I begin in chapter 1 with a detailed description of health care workers on the job. Health care is suffering from an acute shortage of workers. Talented, motivated, and even appropriately credentialed workers avoid or leave the field. The "workforce crisis" can be attributed to a mix of inadequate wages and poor working conditions. Although improved wages are a necessary step in retaining a talented health care workforce, without improved working conditions the commitment most health care workers feel toward their patients and their work will continue to be squandered and exploited. In addition to feeling overworked and underpaid, people in frontline health care jobs are told in a number of ways their work is not valuable and important. Understanding workers' complaints and what motivates them to enroll in training courses allows us to assess the relevance and usefulness of training programs to workers' goals and ambitions.

Chapter 2 briefly describes the health care policy context in which a billion-dollar industry for training health care workers emerged. The prospect of a more market-driven health care system and a greater role for managed care plans fueled the restructuring and reengineering movement that swept through hospitals in the 1990s. It also became the basis for high-stakes, secretive negotiations among New York's health care power brokers, out of which Dennis Rivera emerged with a massive industry to train his union's members.

Chapter 3 defines the scope of the new training industry as it emerged and took shape from 1996 to 2003—who was funded, what kinds of programs were offered, how it was justified as necessary, and what sorts of promises were made. Then chapters 4, 5, and 6 describe in detail three of the most heavily funded training programs in the period I conducted my research. These are multiskilling programs, in particular those designed to transform nursing assistants into PCTs; "soft skills" training in areas such as communication skills and customer service; and individualized

upgrading programs that attempt to help workers create a career path out of the confusing array of occupations in the sub-baccalaureate health care labor market. We will see that these training programs do not address the key problems of health care work: inadequate staffing levels, expanding workloads, lack of material support, and unresponsive structures of authority. Instead, they focus on adjusting the worker to the situation. The training programs in New York City were established when unions, hospitals, and public officials expected massive changes in the health care sector as a result of deregulation and managed care. Characteristically, the response was programs to retrain workers for the "world of the future" rather than to reconsider the terms of employment in the present.

There were, in addition, significant differences between what was expected under managed care and market principles and how pro-market reforms actually unfolded in New York's exceptional political environment. Many of the changes—widespread hospital closings, greater competition for patients and payers, a growing role for commercial insurers, fundamental changes in the nature of health care work—that supposedly necessitated new training did not transpire, or at least were not as drastic as expected. The training industry, however, continued to expand even when the problems it was supposed to solve did not materialize.

Chapter 7 takes a closer look at the different rationales for this industry in order to better understand why the industry persists, even though it fails to solve the basic problems frontline health care workers face. All parties have distinct, overlapping but not entirely compatible interests in the training industry. Employers seek to create a flexible (multiskilled or cross-trained) labor force, decrease turnover, reduce costs, promote conflict resolution skills among workers, and mollify discontent. Labor unions seek to avoid layoffs, retrain workers threatened with displacement, and—as important—promote attachment to the union by offering learning as a benefit and a route to advancement, which functions as an alternative to improving conditions at workers' present jobs. Colleges and universities seek a lucrative market among adults who are perpetually in school, rather than young students who complete credential or degree programs and leave school for work. Private trainers and consultants seek a vast new market for their proprietary seminars and workshops.

Yet, the training and education programs I analyze had consequences that were often inconsistent with such interests. Multiskilling, in the case

of PCTs, did not reduce employers' costs nor did it unquestionably prevent layoffs. Individual upgrading creates opportunities for only a few, and even for them advancement does not always result from their efforts. 1199 may find that training and education programs do not necessarily secure worker loyalty to the union (or hospitals), and that education as a benefit might in fact become a barrier to a fairer and more equitable education system. The $1.3 billion in training funds did indeed open up a vast new market, but the industry cannot be adequately understood in merely cynical terms as a grab for more state subsidies by hospitals and unions or as a payoff they received from politicians in exchange for certain concessions. In fact, one of the main reasons the industry commands continued financial and emotional investment is because those involved recognize that health care workers are in fundamental ways devalued, even if training programs can do little about it (and some training programs even exacerbate the difficult working conditions many frontline health care providers face).

The final two chapters of the book critically examine 1199's role in the training industry for allied health care workers. Chapter 8 explores why 1199 made training and education such a pivotal part of its strategy and how the union's decision to frame its relationship with New York City's voluntary hospitals as that of a "common cause" created a number of strategic dilemmas when it came to the lives and working conditions of the rank and file. Chapter 9 is a historically grounded speculation on what the creation of education as a benefit may portend for the future of education and, indeed, daily life for many Americans. Labor's embrace of employment-based education benefits may have perverse consequences for the collective security of the working class as a whole and the strength of American Labor, as did its embrace of employment-based health care following World War II. 1199 is a labor union that has been, and continues to be, a pivotal force in improving the lives of health care workers. Unfortunately, it has also, at times, placed its own institutional interests above those of its members, not to mention those of a reinvigorated labor movement or the working class as a whole.

I have drawn on several qualitative research projects to compose an account of what the training and education industry for allied health care workers is, and what political (perhaps even ethical) dilemmas it poses. The evidence in the book is drawn from several research projects in which I was involved from 1999 to 2003, each of which examined work in health

care, life in the sub-baccalaureate labor market, and the genesis and significance of a health care workforce training industry, albeit from different angles. First was a study of occupational change in three subacute care facilities (essentially a level of care between that of an acute care unit and a nursing home), with the aim of identifying where workers might need training. Second was an evaluation of a communication skills training program at a midsize teaching hospital in the center of one of the city's poorest neighborhoods.[28] The third study focused directly on individual workers and the emergence of the industry to train them, for which I conducted in-depth interviews and observed several sessions of two additional training seminars—a customer service training program at a public hospital and an in-service on communication at one of the city's largest home health care agencies.

All the studies used qualitative research methods, primarily observations or fieldwork and interviews. For the subacute care study, I conducted observations at three subacute care units from September 1999 to February 2000, for about ten to twelve hours each week. Subacute care units are "step-down" facilities from hospitals, used for short-term rehabilitation and skilled nursing care. Two of the units were located within acute care hospitals, the third was part of a freestanding rehabilitation facility. For the evaluation of a communication skills training program, the research team of which I was a part observed seven 8-hour sessions of the training program, conducted semistructured follow-up interviews with twenty-one staff members (of whom I personally interviewed six), and conducted follow-up observations of staff and their interactions on six different hospital units. The focus of our interviews and observations were nursing assistants (PCTs at that hospital) and unit clerks. In addition, I attended several meetings of the hospital education committee and interviewed two consultants hired by the hospital to run training, including the communication skills instructor.

These two studies, and the conversations I had with health care workers as well as union and hospital officials during them, drew my attention to the extent of restructuring in New York City's hospitals as well as the prevalence of training and education programs. As I carried out fieldwork in health care settings, I was struck by the extent to which workers were exposed to training and education programs. On the job, nursing assistants were constantly being pulled into in-service training or continuing education seminars, where they learned how to operate a new electronic scale,